

**STATEMENT OF
ADRIAN M. ATIZADO
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
May 9, 2007**

Mr. Chairman and Members of the Subcommittee:

On behalf of the more than 1.3 million members of the Disabled American Veterans (DAV) and its Auxiliary, I wish to express my appreciation for this opportunity to present the Subcommittee our views on the present and future state of long-term care programs in the Department of Veterans Affairs (VA). Mr. Chairman, as you know, DAV is an organization devoted to advancing the interests of service-connected disabled veterans, their dependents, and survivors. For the past eight decades, the DAV has devoted itself to a single purpose: building better lives for our nation's disabled veterans and their families.

The DAV is cognizant of VA's need to plan strategically how best to use its resources to provide equitable access for veterans needing acute care services, while also providing a growing elderly veteran population with institutional and non-institutional long-term care services. However, the present state of VA's long-term care program is now lagging behind its rich history as an early leader in caring for aging veterans, and is in danger of falling behind non-VA health care systems. We are concerned that the last published strategic plan for long-term care was prepared over seven years ago. That strategic plan was intended to implement a number of recommendations from a 1998 report of VA's Federal Advisory Committee On the Future of VA Long-Term Care, entitled *VA Long-Term Care At the Crossroads*. This *Crossroads* report took a critical look at VA's long-term care program and highlighted the growing gulf between VA and non-VA long-term care systems. To address this disparity the report recommended swift and definitive action for VA to "...retain its core of VA-operated long-term care services while improving access and efficiency of operations. Most new demand for care should be met through non-institutional services, contracting, and where available, State Veterans Homes." In 1999 a number of the *Crossroads* recommendations to expand and enhance VA's long-term care programs were incorporated in Public Law 106-117, the Veterans Millennium Health Care and Benefits Act, but much of the promise of the Millennium Act remains unfulfilled.

The number of service-connected disabled veterans rated 70 percent or higher for whom VA is required to provide extended care services has been increasing every year and experienced the highest growth from fiscal year 1999 through 2005. Accordingly, the delegates to the 2006 DAV National Convention, held in Chicago, Illinois, once again approved a resolution calling for the expansion of a comprehensive program of long-term care services for service-connected disabled veterans, regardless of their percentages of disability ratings.

Many elderly and infirm veterans, particularly those with service-connected disabilities, use the VA for their health care needs in post-acute and long-term care settings. Today, nearly 45 percent of the over 24 million veterans and nearly 50 percent of the almost 8 million veterans enrolled in VA health care are over the age of 65. The number of veterans over age 85 is expected to reach 1.3 million by 2011. In addition, the majority of VA enrollees plan to use VA as their primary source of health care. Given these projections, the wave of aging veterans will become a geriatric imperative with which VA will likely see a steadily rising and significant demand for long-term care services in the near future.

We are appreciative that in Section 206 of P.L. 109-461 Congress required VA to develop a new strategic long-term care plan; however, we are concerned about the limited time the Act afforded VA in preparing such a critical plan. Furthermore, a March 20, 2006, report by the VA Office of Inspector General indicated VA is developing a Capital Asset Realignment for Enhanced Services (CARES) based strategic plan to address nursing home infrastructure inequities and realignments; however, the DAV is concerned that VA has not sought involvement, input or advice from veterans service organizations with any of these initiatives, unlike the 1999 VA strategic plan for long-term care in which this community was directly involved.

VA's long-term care program received significant modification with the passage of Public Law 106-117, which brought some degree of parity between long-term care, which was considered discretionary care, and acute care, which was considered "mandatory;" however, some tension remains. Furthermore, this tension has translated down and between institutional and non-institutional extended care, where VA is required to provide non-institutional services to all enrolled veterans in need of such care but only requires VA to provide institutional services to a subset of enrolled veterans. Coupling this with the push for VA to drive down the cost of care while increasing the number of veterans served puts long-term care at a disadvantage, and all the more for institutional extended care. The DAV believes that long-term care is a fundamental part of the continuum of VA medical care. We therefore urge Congress and VA to address this aspect of the current state of VA long-term care as you consider the future of this essential program.

Non-Institutional Long-Term Care

As referenced above, VA's enhanced authority to use and make available non-institutional services, including respite care, assisted living and residential care such as adult day health care, skilled home nursing, home-based care models, homemaker/home health aide services, was added to VA's medical benefits package by the Millennium Act. However, nearly four years post-enactment, the Government Accountability Office (GAO) testified and reported these enhanced VA services remained highly variable from facility to facility, and from Veterans Integrated Services Network (VISN) to VISN. The information noted existing variations in availability of non-institutional services across VA due to, among other reasons, the lack of existence of particular programs at a given VA facility and whether the veteran resides within a facility's geographic service area.

More recently VA has reported large year-to-year increases in non-institutional long-term care activity, but VA's data conventions for reporting this workload, which assists VA's ability to manage this program's patient population, are problematic for the purposes of oversight and may misstate that activity.

While we applaud VA leadership in reinforcing the elimination of local restrictions limiting eligible veterans' access to non-institutional care, we continue to receive reports that service-connected disabled veterans are not receiving the care they need for their service-connected conditions because they do not reside in a VA facility's geographic service area. Moreover, we are concerned by the lack of systematic oversight to capitalize and advance the progress made in addressing this issue.

Hospice and Palliative Care

To address the number of veteran deaths that has been increasing by about 8% annually to a current average of 1,800 per day, VA has emphasized providing hospice and palliative care to honor personal preferences for care at the end of life. While hospice and palliative care are covered benefits available to all enrolled veterans in all settings, VA must offer to provide or purchase hospice and palliative care that VA determines an enrolled veteran needs.

Unfortunately, VA is the only public health care system that charges co-payments to hospice patients. Veterans who utilize this benefit may be subject to inpatient and outpatient co-payments if hospice is not provided in a VA nursing home bed.

The DAV recommends the fulfillment of Congress's original intent in Public Law 108-422 that VA provide equitable and compassionate end of life services to veterans by exempting them from the requirement to pay co-payments when they receive VA hospice care in any setting. We also urge greater Subcommittee oversight on VA's end of life programs as many VA facilities have been aggressive in establishing end of life programs while others have lagged behind.

Institutional Long-Term Care

VA Nursing Home Care Units

A common description of nursing home care is that it is the most restrictive and the least flexible mode of providing extended care services. Further, much like hospice care in its infancy, nursing home care is seen as an antithesis to medical care -- a form of care in which patients will never recover or stabilize to the point where they can take care of themselves, or with a support system would be able go return home. While seemingly accurate, these observations do not fairly or entirely represent the value of institutional care, particularly for the veteran patient that suffers from serious chronic mental illness, spinal cord injury, behavioral problems, or is ventilator dependent and thus poses a significant problem for community placement.

On average, elderly enrolled veterans have a higher divorce rate, a higher rate of marital separation, lower incomes, savings and other personal assets than age-matched non-veteran populations. They are more likely to live alone, be estranged from families, less likely to engage in social and community activities, more likely to exhibit unhealthy lifestyles with respect to exercise, alcohol, tobacco, and nutrition, and exhibit more tendencies to chronic mental illnesses. Caring for an aging veteran population with some of these characteristics in the least restrictive setting may well be in VA nursing home care units, rather than in community settings.

Furthermore, the DAV believes that in addition to serving a specific patient population providing invaluable service such as indefinite self-care support, rehabilitative, and recuperative care, nursing home care is an integral component to VA's extended care benefits package as a part of that continuum. Moreover, VA's "Culture Transformation" initiative for nursing home care is centered on such core concepts as personal autonomy, privacy, dignity, flexibility, and individualized services. The culture change movement, which is well underway, is changing the old philosophy of patient centered care, which operates in a medical model of technical service delivery and intervention, and toward the new thinking of patient centered living in old age.

State Veterans Homes

The DAV is concerned about the obvious shift in VA's long-term care workload away from meeting its statutory mandate to maintain VA nursing home capacity. This policy is unconscionable considering VA's own projected demand that the anticipated capacity in all three institutional settings (VA nursing home care units, community nursing homes, and State Veterans Homes) will not be sufficient to meet the total demand of enrolled veterans for institutional nursing services.

While it is laudable that VA seeks to provide care to veterans who need VA the most by shifting more of its institutional care workload into State Veterans Homes, we applaud Congress for taking the first step to provide equitable relief for service-connected disabled veterans in State Veterans Homes through passage of section 211 of P.L. 109-461. This provision authorizes direct VA placement of service-connected veterans in State Veterans Homes, with VA reimbursement to the homes for the full cost of that care. We understand VA is moving forward rapidly to implement that provision with statutory regulations, and we commend VA for that action.

The *Crossroads* report included important recommendations dealing with State Veterans Homes, but one that VA has not implemented nor recommended that Congress authorize. The Crossroads report enthusiastically endorsed VA facilities' making significantly greater use of State veterans facilities to meet enrolled veterans' institutional care needs, rather than building additional VA in-house capacity for that purpose. Unfortunately, VA has done neither. It is true that State capacity has increased to about 21,000 average daily census (ADC) compared to the 1997 level of 14,039 ADC, but proportionately the workload remains at about 52 percent of VA's total nursing home capability. There are ample reasons for this stagnation, related to individual State financial conditions; lack of a formal relationship providing incentives for VA facilities to refer veterans directly to State care; lack of resources to address the growing State home construction backlog (now nearing \$500 million); and, VA legal interpretations that block

better relations between State and VA facilities. VA has long articulated a “partnership” with the States in long-term care, but DAV recommends some of these obstacles be surmounted or legislatively removed in order for a true long-term care partnership to be established between VA and the States.

Community Nursing Home Care

Mr. Chairman, in July 2001, GAO reported to Congress the results of its review of VA inspections of community nursing homes caring for VA-referred patients. As a general rule, VA requires its facilities to inspect State Veterans Homes and contract community nursing homes on an annual basis, and to make staff visits to community nursing homes on a monthly basis. While GAO was satisfied that State home oversight was sufficient at that time, GAO recommended additional oversight by VA Central Office over inspection activities of community nursing homes. DAV recommends the Committee ask GAO to repeat its review of the inspection and monitoring of State Veterans Homes and community nursing homes caring for veterans under VA auspices.

Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans

Mr. Chairman, when we think of long-term care, we assume that these programs are reserved for the oldest veterans, near the end of life. Today, however, we confront a new population of veterans in need of specialized forms of long-term care—a population that will need comfort and care for decades. These are the veterans suffering from poly-traumatic injuries and traumatic brain injuries as a consequence of combat in Iraq and Afghanistan. In discussion with VA officials, including facility executives and clinicians now caring for some of these injured veterans, it has become apparent to DAV and others in our community that VA still needs to adapt its existing long-term care programs to better meet the individualized needs of a truly special and unique population, VA’s existing programs will not be satisfactory or sufficient in the long run. In that regard, VA needs to plan to establish age-appropriate residential facilities, and additional programs to support these facilities, to meet the needs of this new population. While the numbers of veterans sustaining these catastrophic injuries are small, their needs are extraordinary. While today they are under the close supervision of the Department of Defense and its health agencies, their family members, and VA, as years go by, VA will become a more crucial part of their care and social support system, and in many cases may need to provide for their permanent living arrangements in an age-appropriate therapeutic environment.

Unresolved Policy Issues

Nearly a decade after issuance of the *Crossroads* report and enactment of the Millennium Act, and despite encouragement from this Subcommittee and others, VA remains without a clearly articulated policy on long-term care. We commend VA for adding new long-term care programs over those years, especially those dealing with home- and community-based approaches, but we were concerned in 2005 when the VA proposed that Congress further restrict long-term care eligibility and to probably deny access to VA long-term care to major segments of the veteran population, at a moment when the elderly veteran population was peaking. We thank this Subcommittee for its support of a continuation of current eligibility for these services.

As VA has ramped up community-based, non-bed programs such as home-based primary care, it has not changed its reporting conventions such that it still equates a day of care in a community-based or home-based program to that of a day of care in a nursing home or other institutional setting. This type of data collection and reporting may produce a distortion of activity or workload when in fact none may be present.

While VA has become highly efficient at converting its nonservice-connected community nursing home placements to Medicaid status, it has established no formal tie to the Centers for Medicare and Medicaid Services (CMS) or with the States to oversee that unwritten policy. Also with regard to institutional and home hospice, despite offering to purchase hospice VA refers thousands of veterans from its own program to those of Medicare without acknowledging it is doing so, while charging co-payments to dying veterans in its own hospice programs.

In the State Veterans Home program, VA claims to be participating in a “partnership” but only provides a per diem payment to the States as they deal with their veterans’ long-term care burdens. Some VA facilities even deny access to enrollment and to specialized VA care for residents of State Veterans Homes on the basis that the homes are responsible for comprehensive care, not VA.

All these informal policies are working their will, but we question whether they are working to the betterment of the care of elderly veterans or simply are manifestations of ways to shift VA costs for long-term care to other willing payers. DAV does not expect VA to provide long-term care to every American veteran, but to the degree VA holds itself out as a provider of these services, DAV believes the policies under which it operates ought to be transparent and well understood. Neither case is true today.

Closing

Mr. Chairman, the future of VA long-term care planning remains uncertain. The lack of a strategic plan that involves stakeholder input is discouraging to DAV and others in this community. Also, as this Subcommittee conducts needed hearings on VA long-term care services, we urge the Subcommittee to provide stronger oversight of VA’s unwritten long-term care policies to be sure they are equitable for veterans who need such care.

Although DAV advocates for a more comprehensive geriatric and extended care benefits package for service-connected disabled veterans regardless of their percentages of disability ratings, it is clear that VA’s current policy reflects a struggle between what is expected and what it can deliver based on available resources. As the late Dr. Paul Haber said of VA in 1975 on the occasion of the establishment of the VA Office of Extended Care, *“As the number of aging veterans increases over the next decades, the Department will need to expend more resources for their care. Expanding services for old, chronically ill patients will cause disquietude among some in the Department.”* Although he was referring to the “Department of Medicine and Surgery,” now known as the Veterans Health Administration (VHA), Dr. Haber’s words still ring true today. The VHA is forced to choose between emphasizing institutional or non-institutional modes of long-term care, both of which are not available to the same population of enrolled

veterans. These needs must compete internally with the funding of VA acute care and primary care services. Moreover, VA is operating with limited overall health care resources, making allocation decisions ever more difficult, and further hampered by the absence of clear direction due to inequities in existing authority in the eligibility criteria for institutional and non-institutional VA long-term care.

A continuum of care is essential to effectively meet the health care needs of our aging veteran population who live with complex medical, social, behavioral, and functional impairments, as well as to fully meet the needs of the newest generation of veterans injured by war. To ensure that veterans receive the benefits of these programs in a coordinated, integrated manner, a full array of non-institutional extended care services complemented with institutional geriatric care services must be available throughout each VISN, and accessible to all enrolled veterans.

Mr. Chairman, 25 years ago VA published a report entitled *Care for the Aging Veteran*. This was a landmark study and set the stage for many of the programs VA uses today to care for elderly veterans. One of the premises of that era was that VA would take the lead in the “graying of America,” by establishing models of care in geriatrics and gerontology that would be emulated and replicated in other public and private systems of care. While we applaud the obvious progress VA has made, we observe most of the promise that was in the “Aging Report” has not materialized in long-term care policy in the United States. While we hope other Congressional Committees will eventually address the larger picture of an aging America and how to meet those needs, we urge this Subcommittee to establish clear guidelines for prioritizing among VA’s existing and emerging programs and the eligibility of veterans to receive care in such programs. We hope the Subcommittee and your colleagues on the Appropriations Committees of both Chambers will ensure VA has the resources to meet the expectation to provide sick and disabled veterans the levels of care they need, including the needs of the programs we have addressed today in this testimony. Equally important, we urge Congress to continue to hold VA accountable in providing a full complement of high quality, cost effective geriatric and extended care services to aging veterans.

Mr. Chairman, we thank you for holding this important hearing to discuss the state of the VA’s long-term care programs. While I have tried to bring forward relevant issues in long-term care that are important to DAV, the complexity, magnitude and impact of this program compel additional hearings. We urge the Subcommittee to consider holding those hearings in order for Congress to gain a fuller understanding on what needs to be done, for veterans and for all of our citizens as we age. As of today, much still remains despite the obvious progress we have observed.

This concludes my statement, and I will be happy to address any questions the Subcommittee may have.